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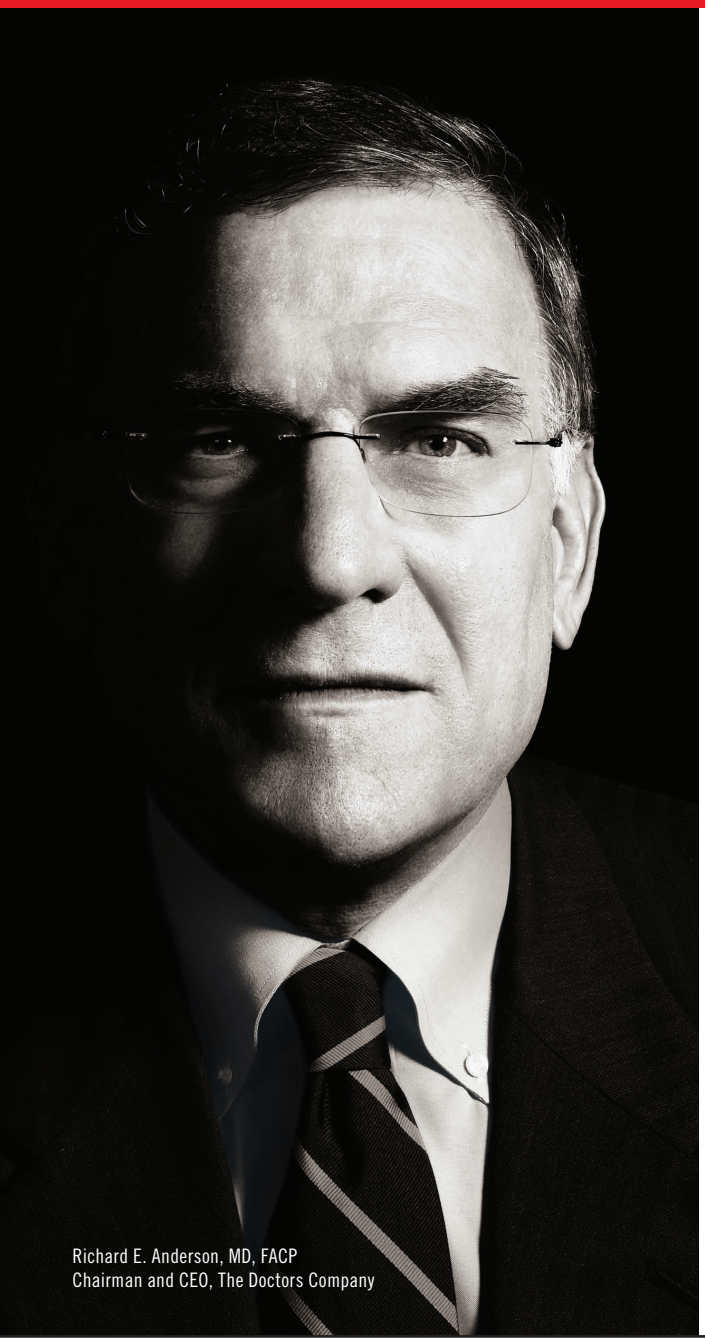

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Volume 63, Number 1 Winter 2012

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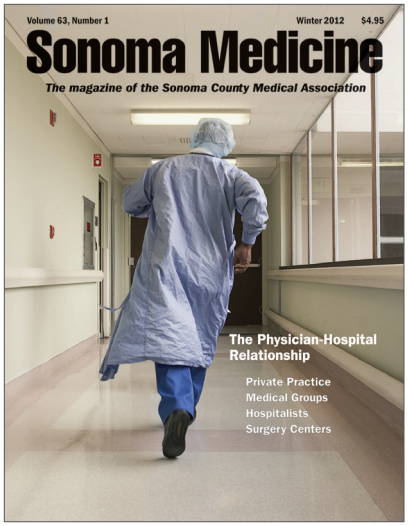

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Sonoma Medicine (ISSN 1534-5386) is the official quarterly magazine of the Sonoma County Medical Association, 2901 Cleveland Ave., Suite 202, Santa Rosa, CA 95403. Periodicals postage paid at Santa Rosa, CA.

POSTMASTER: Send address changes to *Sonoma Medicine*, 2901 Cleveland Ave., Suite 202, Santa Rosa, CA 95403.

Opinions expressed by authors are their own, and not necessarily those of *Sonoma Medicine* or the medical association. The magazine reserves the right to edit or withhold advertisements. Publication of an ad does not represent endorsement by the medical association.

The subscription rate is $19.80 per year (four quarterly issues). For advertising rates and information, contact Erika Goodwin at 707-548-6491 or erika@scma.org.

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Hospital Medicine: The Good, the Bad and the Ugly

Rick Flinders, MD

I left private practice for a full-time teaching career in 1985 and have never looked back. For a little less money and a lot fewer headaches, I found something in life that I love doing, and I feel fortunate to have spent most of my life doing it: practicing and teaching medicine to interns and residents caring for the underserved of Sonoma County. Maybe I'm lucky. But every day I am grateful to the hospital that enables me to practice my calling, and to the residency program that allows me to teach it. As a full-breadth family physician, hospital medicine has remained the one constant among the twists and turns of my practice career. Now it is all I do.

Like everyone else in medicine, I've noticed that things have changed. From my vantage point inside the hospital, I can think of nowhere else that the tumultuous transformation of medicine in the past decade has been more complete. Patients are sicker. Stays are shorter. Diseases are more complex. And the average cost of a day in the hospital is over $4,000, nearly doubling in the past 10 years. At the same time, those of us who provide care to the hospitalized patient are different. Ten years ago, half the family physicians in Sonoma County admitted their own patients to the hospital when they got sick. With the help of appropriate specialists, family docs and general internists admitted patients from their practices, visited them daily, and discharged them from the hospital when they got better. Then they saw those patients back in their offices throughout their recovery.

Dr. Flinders, a hospitalist who teaches in the Santa Rosa Family Medicine Residency, serves on the SCMA Editorial Board.

Pressures of time, efficiency and productivity in ambulatory practice have rendered those days obsolete. Furthermore, solo and small group practices have been absorbed into large corporate systems of health care, creating a new age of relationships between doctors, hospitals, foundations and HMOs. These relationships dwarf the complexities of the Krebs Cycle that I learned in medical school.

Some of the authors in this issue of *Sonoma Medicine* try to untangle the web. The CMA Center for Legal Affairs writes about the legal and financial issues, while local cardiologist Dr. Sanjay Dhar describes a scary encounter over dinner negotiating with the CEO of a large healthcare system. Others, like Dr. Rachel Marek, Dr. Alan Hill and myself, offer perspectives from our experiences with hospital medicine.

The Good

The good news in the hospital is the emergence of new expertise, awareness and experience of the special needs of hospitalized patients, which has spawned a new breed of uniquely trained physicians to care for them: hospitalists. Dr. Marek, for example, directs Memorial Hospital's pediatric hospitalist program and practices hospital pediatrics with all the values and dedication that drew her to the specialty in the first place. She writes how hospital medicine enables her to focus her attention and skills on sick children in the hospital, where she enjoys "the immediacy of the moment-to-moment intellectual challenges that the hospital provides, and … working together as a team with the other physicians, nurses, therapists, social workers and other support staff to better care for patients." I'm sure the same could be said for hospitalists caring for adult patients throughout Sonoma County.

Also good is the irreplaceable value of the hospital as classroom, what I call "the crucible of medical learning." From the perspective of a lifelong medical educator, I insist the practice and teaching of medicine in the hospital remains the single most hands-on, intense, intimate and sustained model we currently have to teach doctoring. Daily I'm asked why we should continue teaching inpa-

tient medicine to a specialty that spends 99% of its time outside the hospital (see Table 1). Anyone who has ever labored through a long night at the bedside of a sick patient doesn't have to ask. *Dude,* it's about *doctoring.*

The Bad

Alas, the new hospital model has not come without a price. Despite advances in expertise and efficiency, as well as improved outcomes, the primary care relationship between doctor and patient has suffered. You'd be surprised by how much effort we hospitalists make to communicate with our patients' primary physicians, after admission and prior to discharge. You'd be amazed by the barriers encountered in those efforts to communicate. Patients arrive without advance directives or POLST (physician orders for life-sustaining treatment), and our discharge summaries, even in this age of instant electronic communication, are thwarted by user names, passwords, EHR affiliation agreements, and incongruence of availability and schedules.

A phone call used to be: "John, this is Rick. We admitted Mrs. Z last night. Probably home in a couple days. We'll alert you prior to discharge. Anything you want us to know about her?" John would then tell me what might also be helpful, if not essential to her care (likely based on years of knowing and caring for Mrs. Z). In this age a phone call is more likely a voice message or a telephone "encounter" launched into the ether. Did John really get my message? Or is he going to be surprised when Mrs. Z shows up in his office and tells him she was recently hospitalized? And will he really have the summary of her care, discharge instructions and medications?

Disruption of continuity and multiple sign-outs and hand-offs, both in care and learning, are a constant threat in the new medicine. The electronic health record, powerful as it is, is not a substitute for the relationship with a patient over time. I try to teach our residents, for example, that the patient's history is not really complete until you've actually spoken with the primary physician. Am I a voice in the wilderness?

Table 1. Top 10 Reasons to Continue Teaching Family Physicians Inpatient Medicine

1. The Residency Review Committee requires it.
2. What we do and learn from the inpatient experience transfers to outpatient skills and practice.
3. We are training family physician hospitalists, rural medicine and developing world docs.
4. Inpatient medicine intensifies and concentrates medical learning and practice.
5. Family medicine presence in the hospital is helpful for teaching our own students (and specialists) the unique role of family physicians.
6. Inpatient medicine is a "developmental stage" in the formative, learning crucible of medicine.
7. Inpatient medicine exposes residents to intimate moments of life and death.
8. Strong medicine experience continues to attract strong applicants.
9. We're pretty good at it.
10. Forget about "outpatient" vs. "inpatient" curriculum, and think "doctoring." Inpatient medicine remains the most hands-on, intense, intimate and sustained model we currently have to teach doctoring.

The Ugly

In 1998, the Institute of Medicine released a report that attributed nearly 100,000 deaths annually to medication errors in the hospital, drawing national attention to just one of the many known risks of being hospitalized. We must remember that hospital patients—by definition—are already sick and at higher risk of mortality. Still, it remains ironically disturbing that our houses of healing can be hazardous to our health.

The hazards of hospitalization (see Table 2) are now on our daily radar. Blood clots and hospital-acquired infections, especially with hospital-bred superbugs, remain especially significant threats. Early identification and prophylaxis of thromboembolic risk and prudent use of antibiotics are part of hospital-wide initiatives at Sutter, for example, to establish a new "culture of safety" in hospitals. In addition, electronic delivery and verification systems have already produced dramatic reductions in medication errors since 1998. Progress, but …

Table 2. Top 10 Hazards of Hospitalization

1. Medication errors
2. Venous thromboembolism
3. Nosocomial infection
4. Iatrogenic complications
5. Aspiration pneumonia
6. Immobilization and deconditioning
7. Ulceration (skin and gastric mucosa)
8. Malnutrition
9. Disorientation (from "sundowning" to ICU psychosis)
10. Bankruptcy

You may notice among the hazards in Table 2 one not seen on the usual lists. I added it because it is especially ugly, and especially frightening: bankruptcy. Unpaid medical expenses are among the leading causes of bankruptcy in the United States, especially among the elderly. The biggest fear cited in a recent survey of Americans 65 or older was not war or terrorism; it was financial ruin from medical expenses.

There is inherent risk in what we do in the hospital, and we can only minimize it. But we can also remember that every potential benefit must be weighed against the risk. "Primum non nocere," Hippocrates said (First do no harm). I sometimes wish our grand old man of Western Medicine hadn't said it so well. Eloquence, especially when familiar, can become cliché. We all know the words. But do we still really hear them? ◇

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You Will Be Assimilated

Sanjay Dhar, MD

What are the chances that a solo practitioner in the current toxic environment can make it against the Goliaths of the corporate healthcare world? Slim to none! With this thought in mind, and with an instinct for survival, three physicians and I recently huddled at a corner table in a fancy local restaurant with the CEO of a large healthcare network. After he presented us with pages of statistics from his shiny dossier, he lifted his glasses, sipped some Pinot, and said in a soft-spoken voice, "This is our last offer. We are the only viable game in town. If you guys don't join us, we will find someone to replace you. I am not sure how long you can act like dinosaurs. You will become extinct or you will be assimilated."

***Star Trek* Captain Jean-Luc Picard (Patrick Stewart) after assimilation by the Borg.**

These words sent a chill down my spine, and my head started spinning. I felt as if the massive cybernetic Borg machine from Star Trek was here to eradicate our individuality and demolish what we stood for or offered to our patients. The CEO had all the numbers about our "performance" over the last three years. He had mathematical models predicting what our billing and collections would be like, based upon our current performance and insurance contracts. He also let it be known what we would be making sometime in the distant future, as if we were an amortized mortgage account statement. In all this mind-bending data, only one thing was obvious to me: All the graphs were pointing down.

Dr. Dhar is a Santa Rosa cardiologist in private practice.

The CEO raised his voice and said something that made him look like the ringleader in a caveman story: "We have Killer Insurance Contracts that you guys don't have access to." After a long night of reluctance to pay attention to any of his statements, I had to admit that there was some truth in his last utterance. The disparities in medicine in a free economy, such as ours, are particularly distressing for an individual practitioner who doesn't have good contractual relationships with insurance companies. In layman's terms, large groups are paid better for the same service provided by a smaller group or an individual practitioner. For some reason, insurance companies want solo practitioners to be assimilated or wiped out so that others can get paid more. The mathematics of this arrangement don't make any sense, but it is nonetheless a bitter fact that I have to live with every day.

In the corporate-driven world of healthcare, graduates from famous MBA programs want to identify our patients as consumers or customers. We hand the MBAs practice satisfaction cards because some highly paid consultant told us to do so, but in the end we don't even know what they do with the data collected. It's like looking at the back of a truck that says, "Call this 1-800 number to let me know how I am driving."

If I do get assimilated, what will my future be? In the current rush to reach cost-effective healthcare, the powers that be would like to treat us as factory workers and our patients as inanimate objects stretched out on a long assembly line. I will be forced to practice evidence-based medicine and follow predetermined clinical guidelines. Every day, I see patients who fall out of these well-defined boxes for treating

chronic diseases, leaving me wondering who came up with those guidelines. I know that every patient and every problem is different and I can't offer a "one-fit" glove response to everyone. The irony of all these strict guidelines is that even after 2,500 years, we still don't know the correct dose of aspirin for our patients. If something as simple as that is not clear, how we can thrust complex guidelines for complex chronic health conditions down the throats of our fellow physicians?

In this era of clinical data entry, I feel I have become a data entry clerk (with no disrespect to their profession). I didn't go to medical school to become an expert typist. I find myself spending more time looking at the computer rather than the patient. I find myself struggling to make my clinical note longer so that I fulfill some random criteria for billing. I feel that I have to wrestle with the clock so I can mention that I spent 27.5 minutes with my patient. I fear getting penalized if I don't mention that I did inquire from my 98-year-old patient if she smokes. The fear is that failing to ask would prevent me from getting a financial kickback or a pat on my back from Medicare or an insurance company as part of some weird carrot-and-stick reward system invented by the echelons in Washington, DC. Why can't I be rewarded for just taking better care of my patients? Why can't I maintain my professional excellence and practice individualized medicine rather than toil as a factory worker who gloomily checks in and out every morning and evening? The lack of interest on our faces doesn't behoove well for future generations who think it is a crazy idea to become a doctor. We have to attract creative, smart and independent thinkers who not only have expertise in science and biology, but also an authentic focus on humanism and caring.

The techie-driven 21st century exposes us to buzz words like ACO, cloud computing, CPOE, denial management software, EMR-EHR-HIT interoperability, meaningful use, creative destruction, satisfaction scores, affordable care acts, mobile healthcare apps and medical loss ratio. These terms not only don't help my practice in any way, but they also give me a big headache and distract me from my primary focus of taking care of my patient's problems.

Yes, I may be a dinosaur heading toward extinction because of tremendous economic pressures, long hours, hard work and impending Medicare pay cuts, all of which weigh heavily on physician-owned practices. It's becoming increasingly difficult for us to run a profitable practice, spend time with patients and have a life outside of the office. It's no surprise that about half the physicians hired out of residency and two-thirds of established physicians were placed in hospital-owned practices during a recent one-year period.

With so much talk about financial struggles and day-to-day hassles, it's easy to lose sight of the positive side of being a physician. There are several reasons why we should be happy: we always have a job; our days are filled with variety, including diagnostic challenges and intellectual treasure hunts; we prevent illnesses as well as treat them. These reasons should give us a sense of pride and satisfaction. Patients still respect us, and we can act as great teachers, philosophers, friends and advisors.

But are physicians happy? To discover the answer, I recently conducted a 10-question survey of Sonoma County physicians. The survey included questions such as these:

- Are you happy in what you are doing currently?
- If you are not happy, then what will make you happier?
- What things would you like to see change in your career?
- Have you contemplated leaving your practice for greener pastures?

The bitter reality is that 90% of the physicians who responded to the survey said they were unhappy. Their answers were surprisingly different from person to person and from specialty to specialty. Here is one of the best responses:

> We all complain about call. Most of us would rather not take call, even if paid a stipend. If we take call, the fewer the calls the better. However, most of us do what we do because the ability to help patients is deeply gratifying. Most of the time, the patients and their families are grateful that we are there when they need us and a simple "Thank you, doctor" makes the difference. Giving of ourselves to them is (or should be) more valuable to us as human beings than anything else we might actually do with that time we spend on call. It comes down to our society's focus on the primacy of "me first." Call seems burdensome not so much because it is physically demanding but because of the conflict between the deep desire to give to others and the societal pressure to "look out for ourselves first."

According to my survey, the physicians in Kaiser and other large group practices seemed to be the happiest. When I questioned them further, however, I began to wonder if they were happy because they were ignorant of their true worth. If told exactly what their salaries were compared to the work they had put in or the revenue they had generated, they might not be so happy after all. But it was also obvious that they had taken that route because they wanted it that way and knew they were sacrificing something to get some element of happiness. In the end the survey did reveal the interesting fact that it would not take too much of a change for an unhappy physician to become happy or content with his or her style of practice. In our free style economy there is still room for Wal-Mart, K-mart and Nordstrom to co-exist and thrive successfully.

Meanwhile, I am keeping a close watch on my credit line and on the checks coming from the insurance companies. Private practices like mine are an important part of the varied healthcare topography. I would like some parity and respect for my individuality. Here's to hoping that I won't get assimilated. Beam me up, Scotty. ◇

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A Perspective on Hospital Affiliation

Allan Hill, MD

I first came to Sonoma County's medical facilities as a medical student in 1981, when I was eager to be a family physician. UC Davis had a rotation available with the Santa Rosa Family Medicine Residency and other programs that trained doctors for rural practice in California. I had a great experience at Community Hospital, where medical students lived in the flophouse across from the ER entrance and made Friday night pilgrimages to the Acapulco Restaurant for dinner. During my rotation in Santa Rosa, I had no firm plan of where and what my medical practice would be, and that same situation has held somewhat true ever since.

After returning to UC Davis, I decided to become a surgeon and was eventually hired at the Kaiser facility in Santa Rosa in 1989. Despite my intentions to enter private practice in the mid-portion of the state, life intervened, and I stayed with Kaiser for 11 years. I then went into private solo practice in Sebastopol after Dr. John Sweeney retired. After 10 years of solo practice, I joined the Sutter Medical Group of the Redwoods.

The only hospital in the county that I haven't operated in is Sonoma Valley. Like most general surgeons, I almost always have at least one patient to tend to in a hospital somewhere. Given my history, I have some perspective about a surgeon's relationship with hospitals and how that can differ in various practice settings.

Dr. Hill, a Sebastopol surgeon, is affiliated with the Sutter Medical Group. Email: ahillmd@sonic.net

My decision to leave private practice involved three main issues. First were the daunting requirements from regulatory and governmental edicts. In particular, I was using an electronic system that was a horrible medical record but a serviceable billing tool. Getting a better EMR was going to be expensive and time-consuming. The second issue was contracting. The individual has no power in negotiating contracts with payors. While my overhead was increasing, my payments were stagnating or decreasing. My last concern was my slowly shrinking referral base in Sebastopol. Without significant growth in primary care, and with market shifts and expected retirements, I needed a broader network for referrals. My choice of the Sutter system was based on the best fit for the issues listed above. Sutter was the venue that allowed me the most choices regarding the actual practice of medicine.

The main attraction was that Sutter is not a closed system for physician relationships or facility choices. Having options for surgical care is important to me and my patients. A surgeon needs a hospital to do inpatient procedures, and an affiliation with a medical group that has some connection to a hospital is a plus. I must say that belonging to such a group has not affected how I care for patients. I am at the Sutter hospital more than I was in private practice, but that is related to the changes in my referral base.

I have had several hospital relationships during my career. At Kaiser, I had one hospital to use and complete overlap of hospital and outpatient medical group affiliations. This did cut down on driving, but there wasn't much available as far as choice for me or my patients. In private practice, I was affiliated with Palm Drive Hospital by choice. In fact, part of my reason for going into private practice was an interest in keeping that hospital open. In Sebastopol, when resources were limited, there were hospital options in the county and referral options to tertiary care centers when needed. Palm Drive does what it does very well, but the hospital does have limits in some of its onsite care capabilities.

As a member of the Sutter Medical Group, I have an interest in the Sutter hospital's success, but I can still offer choices of surgical facilities to non-HMO patients. I am frequently reminded that some freedom of choice, in all aspects of our lives, is a motivator and a condition of living in a free society that is worthy to maintain.

Being affiliated with a hospital system also brings a motivation for the hospital to maintain an interest in its surgeons. As changes occur because of physician-facility collaboration, I hope the hospitals I am active in will want some of my input on how those changes should occur. Being able to have input on the workings of a hospital where you carry out a significant portion of your work life is a benefit.

In a more practical view, as the hospitals get beleaguered by more

and more regulatory and economic requirements, the ability to at least soften the share of that burden assigned to physicians is a good thing. We may not like the way we have to document our hospital work and answer to the requirements of outside influences, but it isn't a trend we can ignore. Failure to be involved in change has had negative results for the medical profession in the past.

Considering all the above, the change to Sutter Medical Group has been a positive move for me. Because Sutter is not a closed system, I am still able to participate in medical care in the Sebastopol area, and also to be somewhat active in Healdsburg and, of course, Santa Rosa. I see all these hospitals as important community assets that need to function well to ensure good patient care throughout our county. I do feel there is more financial security in a group, and as we deal with health care reform, a working relationship or partnership with a hospital will become more important. ◇

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The Wave of the Future is Now

Rachel Marek, MD

I didn't grow up envisioning myself as a hospitalist. In fact, I grew up envisioning myself having a distinguished career as a crossing guard, or becoming an accountant, like my dad. That was when I thought accounting had nothing to do with taxes and everything to do with counting things like the Count on Sesame Street.

When I tell people outside of medicine that I am a pediatric hospitalist, I am often met with puzzled expressions and looks of bewilderment. I would never guess from their confusion that the term *hospitalist* was coined 15 years ago by Drs. Robert Wachter and Lee Goldman in the *New England Journal of Medicine.* They defined hospitalists as physicians who "concentrate their professional activities on the care of hospitalized patients as opposed to ambulatory patients." Specifically, they defined hospitalists as "physicians who spend more than 25% of their time based in a hospital setting where they oversee hospitalized patients and then return these patients to their primary care physicians at discharge."

While the field first began in adult medicine, it eventually encompassed pediatrics as well as other specialties. In 1996, there were a few hundred hospitalists in the United States, but in 2011 that number was closer to 30,000, with hospitalists both in major academic centers and local community hospitals. While this rapid growth certainly has been a response in part to the ever more restrictive and changing ACGME residency work hour requirements, it also has been spurred by the increasing complexity of the inpatient population and the shifting medical economics, which encourage physicians to focus either on their office-based practice or hospital medicine.

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Although more and more hospitalist fellowship programs are popping up around the country, most hospitalists, especially in non-academic settings, have completed a three-year residency without a fellowship. There is no subspecialty board for hospitalists either in internal medicine or pediatrics; however, the American Board of Internal Medicine has endorsed a concept of "recognition of focused practice," and the newly formed Joint Council of Pediatric Hospital Medicine is actively exploring similar options, including a hospitalist residency track, extra training, and a three-year fellowship. Much of this lack of subspecialty definition stems from the rapid growth of hospital medicine, which has evolved over the past decade from primary care doctors making daily rounds to a generalist hospital-based practice with acutely ill patients.

My own journey to pediatric hospital medicine certainly did not follow a clear-cut path. When I was a medical student at the University of Michigan, I remember hearing about this new breed of doctors: hospitalists. They cared for patients in the hospital without necessarily spending time in outpatient clinic, but I was worried I would miss the continuity of seeing patients in the office year after year and developing those long-standing relationships. Being in the hospital full time certainly was not the image I had foreseen for myself as a doctor. I, like many of my predecessors, anticipated a career of seeing patients in the office throughout the day—some sick, most not so sick—with very occasional rounds in the hospital just for good measure. I definitely did not yet envision myself as a hospitalist.

However, as with many things in life, the decision to become a hospitalist was an evolution over time. When I started residency at Children's Hospital Los Angeles, I realized, strange as it is to say, that I enjoyed taking care of sick children. That's where I felt like I made the most difference. The majority of my residency was spent on the inpatient wards caring for children with diagnoses ranging from Omenn syndrome and neuroblastoma to the more routine asthma and bronchiolitis. I relished the immediacy of the moment-to-moment intellectual challenge that the hospital provides, and I enjoyed working together as a team with the other physicians, nurses, respiratory therapists, social workers, and other support staff to better care for the patient. As my three years in Los Angeles drew to a close, I no longer envisioned my pediatric career as a primary care doctor, seeing patients in the office at

scheduled intervals, but rather rounding in the hospital as a hospitalist.

After finishing residency, I was fortunate to get my first "real" job (translation: I could now start paying off my medical student loans and stop relying on my parents for occasional stipends to make ends meet). I became a pediatric hospitalist at Santa Rosa Memorial Hospital not 20 miles away from where I grew up in Sonoma. I love talking to new parents so filled with joy and anticipation about their baby. And I love reassuring moms and dads when their child is sick and needs to come into the hospital. I am very lucky to work with a superb group of doctors and nurses.

Pediatric hospitalists first came to Santa Rosa Memorial Hospital in December 2005 due to the combined efforts of local pediatricians. After years of taking call from home and driving into the hospital at all hours of the day and night for a sick newborn or a critically ill child in the emergency department, they worked with the hospital administration to start a hospitalist program for pediatrics. This was a big and undoubtedly welcome change, but in fact, it was catching up with the trends in the rest of medicine. The effervescent and always energetic Dr. Grace Martin was the first hire, and three more hospitalists (including me) were added in the summer and fall of 2006. In November 2006, we became a 24 hours a day, seven days a week service in the hospital. And we haven't looked back.

Over the past five years, the pediatric hospitalist service has grown considerably, but one thing has stayed constant: no day is like the one prior. There is always some new wrinkle to keep me on my toes or, as I like to say, to satisfy my professional ADHD. The role of pediatric hospitalists can vary widely from institution to institution. They may teach, do research, supervise residents, see children on the ward, and examine babies in the nursery, or all those things and more. The variety is nearly endless.

So what does my job entail? In my role as a pediatric hospitalist, I get to wear many different hats throughout the day, from seeing a well-newborn, to reassuring parents about their ill child, to attending a delivery of a baby with meconium, to seeing a child with pneumonia on the pediatric ward, to examining a teenager in the emergency department after an auto accident, to getting a phone call from Clearlake about a child with asthma who needs admission. There is rarely a dull moment.

When a patient is cared for by the hospitalist team, it means that she will see someone other than her primary medical doctor while hospitalized, but this relationship is predicated on excellent communication both at admission and discharge. Handoff of all clinically relevant information is vital. As pediatric hospitalists, we care for nearly 100% of all the pediatric admissions at Memorial Hospital, but we realize that we do not work in a vacuum. We strive to provide a safe haven with quality, family-centered care when children are acutely ill and need hospitalization, but we rely on the excellent follow-up the children receive at their medical homes in the community.

Over the past 15 years, as hospitalists have increased in number, so has the interest about their effect on quality of care. Studies have reported time and time again that hospitalists have been shown to provide high-quality outcomes with decreased average lengths of stay and decreased costs while maintaining both patient and referring physician satisfaction. In short, there is improved efficiency of care; it is both timely and readily available. When I have a hospitalist shift, I am in the hospital for a twenty-four hour stretch meaning I can examine my patients multiple times during the day and change my clinical management if needed. I also can talk with the families at 10 a.m. and then again at 10 p.m. and anytime in between to update them on their child's care and plan. Under traditional practices, patients might see their doctors once a day during their routine rounds. With hospitalists, nurses also are not left hanging awkwardly wondering if they should call or not with a pertinent clinical question, especially during the middle of the night when waking a tired doctor can be challenging. I like to check in and update the pediatric nurses several times during the day, so we are all on the same page with the plan for each child helping all of us work better together as a team. High quality of care is now available day and night, 24/7.

I love the fact that I get to practice medicine, really practice medicine in the way which I was trained without worrying about a patient's insurance status or ability to pay. The hospital setting allows me to be a doctor without administrative strings from insurance companies and the like dictating the medical plan. I like being able to come in for my 12- or 24-hour shift at the hospital, work hard, and then go home to have a long nap without worrying about the pager going off.

How have we changed pediatric care in Sonoma County? Well, I like to think that it is indisputably better. Pediatricians throughout Santa Rosa, regardless of their hospital affiliation, have utilized the pediatric hospitalist program. They all agree that this has improved healthcare for children throughout the county, combining two declining and underutilized wards at Sutter and Memorial into one stronger unit based at Memorial Hospital. (Note: Kaiser in Santa Rosa also has a pediatric hospitalist program.) Our presence in the hospital allows those same pediatricians to focus on their office practices without worrying about being pulled away abruptly from a patient visit because of a sick child in the emergency department or a problem delivery. We also have the opportunity to work with many other departments in the hospital, from surgery to the intensive care nursery to trauma to the emergency department—keeping an extra set of pediatric-trained eyes on the children admitted to Memorial whether it is a 6-year-old who just had his appendix removed or a 9-year-old being observed after a bicycle accident.

By having a pediatric ward in Santa Rosa, we can care for the children of this community within our county, thereby decreasing the number of children who need to be transferred to San Francisco or Oakland for their care. Needless to say, this is much easier for their families, and it allows relatives and friends an opportunity to visit a sick child in the hospital without crossing a major bridge. Since we are the only non-Kaiser pediatrics ward in Sonoma County, we get phone calls from outlying hospitals in Sonoma, Petaluma, Sebastopol, and Lake/Mendocino Counties about pediatric admissions. We work with outside emergency departments and primary care doctors to quickly, safely, and efficiently transfer sick children to Memorial whenever possible.

Can we take care of every child at Memorial Hospital? No, we do not (and should not) have a pediatric intensive care unit, and we have very few subspecialists. However, we know what we do well and strive to continue to do so while realizing that sometimes the best care for a child means being in a tertiary care hospital. Undoubtedly, though, it is certainly beneficial to have a community hospital with pediatrics right here in Sonoma County.

What changes have occurred in the five years I have been at Memorial Hospital? It is almost like night and day. The pediatric ward has gone from being an appendage at the end of an adult med-surg floor to a vibrant 12-bed, 12-room pediatric ward with security cameras. We have gone from having one nurse on duty at a time to 2-4 nurses a shift. Our admissions have skyrocketed over 225% from 2005 to 2010, and we are continuing that trend this year as well. And we look forward to more growth and change in the years to come. Maybe one day we will have a child life specialist and an official designation by the State of California as a pediatric ward, but until then we are just going to keep working hard to provide the best care for the children of this community. So do I envision myself as a pediatric hospitalist for many years to come? I certainly do now. ◇

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The Endoscopy Center of Santa Rosa

Michael Lustberg, MD

Physician-owned surgery centers provide surgical services in a relaxed, safe and efficient setting. Some specialties, such as gastroenterology, are more suited to this environment than others. The key factors that determine whether a physician-owned outpatient surgery center will be successful include the projected volume, revenue and expenses, and most important, the ability to obtain fair contracts with insurance companies.

The demand for gastroenterology procedures, particularly colonoscopies, has greatly increased since colorectal cancer screening guidelines were developed in the 1990s. The success of the subsequent public awareness campaign was partially due to Katie Couric's efforts to promote colon cancer screening after her husband died of colon cancer in 1998 at age 42. Four years later, millions of people watched as she televised her own colonoscopy on the Today Show.

In 2001, colonoscopy became a covered benefit for Medicare recipients at average risk for colorectal cancer, and private insurers soon followed suit. Like many other surgery centers around the country, the physician-owned Endoscopy Center of Santa Rosa opened in 2002, after coverage and contracting became possible. Colon cancer screening rates, while traditionally low, have continued to rise and are now greater than 60%.

Dr. Lustberg, a gastroenterologist at Digestive Health Consultants of Northern California, is CFO at the Endoscopy Center of Santa Rosa. Email: lustberg@dhco.pro

Data continues to support the use of colonoscopy as a screening tool, and the overall age-adjusted mortality rate from colorectal cancer has actually been decreasing. According to the Centers for Disease Control and Prevention, approximately 66,000 fewer Americans developed colorectal cancer, and 30,000 deaths were prevented, because of colorectal screening and other improvements in our health care system from 2003 to 2007.[1] Most of these patients were screened with colonoscopies.

The recent U.S. Preventive Services Task Force guidelines on colorectal cancer state that colonoscopy is a test of cancer *prevention*.[2] Other tests, such as fecal immunohistochemistry (FIT), are considered measures of cancer *detection*. During a colonoscopy, precancerous polyps or early cancer can be removed. Even if subsequent surgery is required, early cancer detection results in a cure approximately 90% of the time.

The increase in colonoscopies has been accompanied by rapid advances in medical device technology. The trend is toward increasingly advanced, less invasive and more effective treatments.

All the variables mentioned above have led to an ongoing demand for endoscopic services in an outpatient setting. Direct colonoscopy screening accounts for about 30% of the procedures performed at the Endoscopy Center of Santa Rosa, and colonoscopy in total is about 85% of all procedures performed at the center. These percentages are similar to national data.

But what is driving the development of *physician*-owned surgery centers? Quite simply, cost. Our endoscopy center is the most cost-efficient facility between Petaluma and Ukiah. We strive to provide the highest quality of care and use the most up-to-date equipment, such as high-definition narrow band imaging endoscopes and high-definition progressive scan monitors. Some evidence suggests that this equipment allows for better detection and removal of neoplastic polyps and early cancers. The insurance companies have this data and encourage their patients to come to centers such as ours. Patients, too, search for high quality care at low cost, just like any other commodity.

Physicians who are involved in managing and owning their practices or surgery centers are looking for certain factors. They want improved control of their practices so they can, for example, schedule procedures with greater speed and flexibility. They are also looking for ancillary income, and they want improved delivery of care. Physicians make up the governing bodies in their surgical centers, and the governance process is usually streamlined. Purchasing decisions can be made quickly in response to clinical or market forces.

Physician-owned surgery centers have certain competitive advantages. First, they have direct negotiating power due to volume and market control, which allows for low-cost purchasing contracts. Second, payer contracts

for the facility fee are relatively low compared to hospital-owned centers. This cost difference increases demand for services at the physician-owned centers, particularly among patients in high-deductible commercial insurance plans. Low facility fees may also help physicians negotiate their office fee schedules when insurers bundle facility and physician fees in a DRG model, as some are starting to do.

A third competitive advantage of physician-owned centers is that they control the acquisition of endoscopic quality data via electronic medical records to further refine and improve care. This task isn't currently possible at other facilities. The quality data can be used with insurance companies to help obtain contracts based on quality of care or the true cost and benefit of capital purchases.

Along with competitive advantages, physician-owned surgery centers have many challenges. Physicians have developed risk aversion because of perceived threats to reimbursement, such as ACOs, physician group consolidation, stagnant or decreasing Medicare reimbursement, and a drop in overall wealth due to the recession. Medicare facility reimbursement has actually decreased for some specialties. In fact, gastroenterology has decreased the most, approximately 20% in the past two years. Medicare has also dropped reimbursement for outpatient surgery centers to 56% of hospital outpatient department rates. Additionally, the number of Medicare and Medical Assistance patients is increasing both locally and nationally. This will put downward pressure on the average payment per case. Meanwhile, the cost of doing business has increased, due to Medicare compliance regulation and audits, EHR implementation, and mandatory quality data reporting.

Nonetheless, the trend for high-volume, efficient, minimally invasive procedures is likely to continue if clinical evidence supports their efficacy, such as with colonoscopy and colorectal cancer screening. The location of the procedure will likely be driven by the lowest facility cost and documented quality performance. Consolidation of centers or those operated by larger companies will likely benefit the corporations themselves—in the form of greater facility reimbursement due to less competition and/or higher fee schedules—and not the patients, at least in terms of cost.

The challenge for physician owners in the future will be to balance the interests of their patients with the detriment of potential decreasing reimbursement and increasing administrative burdens. The benefits—including autonomy, patient and physician performance satisfaction, and ancillary revenue streams—still remain significant. ◇

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Advantages of a Physician-Run, Hospital-Owned ASC

Michael Lazar, MD

Santa Rosa Memorial Hospital opened its Ambulatory Surgery Center (ASC) near the hospital in 2003 to expand access to care, adapt to consumers' changing needs, maximize convenience for patients and families, and ensure clinical quality and patient safety in a setting conducive to outpatient care. The center's development followed a nationwide trend toward same-day surgeries. The rise of minimally invasive techniques during the 1980s and 90s transformed surgeries that once required an overnight hospital stay into procedures suitable for outpatients. In the 1980s, about 15% of surgeries in the United States were performed on an outpatient basis. By the 1990s, when planning for Memorial's ASC began, that proportion had reached 70%.

At the ASC, Memorial maintains 100% ownership of the facility, while I and fellow physician investors in a limited liability company that contracts with the hospital are paid for running the surgery center. Our company (Santa Rosa Surgical Management Company, LLC) pays an on-site director to supervise services at the center, but Memorial employs the remainder of the ASC's 22 staff members. This agreement between the hospital and the LLC allows physicians more direct control and input in meeting quality standards, while reducing significantly the monetary outlay and financial risk associated with establishing our own facility.

Dr. Lazar, a Santa Rosa urologist, is managing physician director of the Santa Rosa Memorial Hospital Ambulatory Surgery Center.

The combination of physician oversight with the medical and financial resources of Memorial Hospital has yielded a stable resource that's well positioned to meet community needs for years to come. National health care reform is driving greater reliance on an integrated, broad spectrum of care that stresses lower-cost alternatives to acute hospital-based treatment, and the ASC plays a much-needed role in that continuum.

At the same time, the proportion of Sonoma County residents age 65 and older has increased at about three times the rate of the rest of our local population. As patients in this age bracket require health care services, we will be challenged to deliver surgical treatment more efficiently—an advantage offered by ambulatory surgery centers.

Located on the second floor of a 17,000-square-foot, two-story building on Doyle Park Drive, in close proximity to Memorial and other medical offices, the ASC features six operating rooms, six pre-op beds, 12 recovery beds, a spacious waiting area, a covered drive-up entrance, and adjacent parking. We provide a wide variety of specialty care and procedures, including urology, gynecology, orthopedics, general surgery, plastic surgery, pain management, ophthalmology (oculoplastics), and otolaryngology.

On-time surgeries are one of four key metrics on which our performance as an ASC clinical team is judged, and for which we as a management company are held accountable. These primary performance objectives are:

Patient satisfaction. Our benchmark calls for patient satisfaction scores of at least 92.4%, meaning better than 9 out of 10 patients rate us well on patient satisfaction surveys. Postoperative surveys tell us how favorably our patients view the caliber of their care, as well as their comfort and the environment at the ASC.

Process improvement. To minimize wait times for patients, staff and fellow physicians, the attending physician is required to be in the operating room suite within 10 minutes of the start of the first scheduled procedure of the day. This sets the pace for the remainder of the day, ensuring subsequent surgeries do not get backlogged.

Quality. We strive to achieve 100% compliance with universal protocols for "time outs" immediately prior to any procedure. We have demonstrated 100% compliance with that standard during the first three quarters of 2011.

Patient safety. We commit to reducing the risks of postoperative infection

through adherence to strict protocols and thorough postoperative evaluation of each case. Throughout 2011, we have kept the infection rate below 0.01%.

One advantage to physicians who invest in or practice at a hospital-owned ASC can sometimes prove an obstacle—namely, the hospital's responsibility for purchasing and maintaining equipment. When hospital resources allow for new equipment to be purchased, physicians and patients benefit from upgraded instrumentation and technology that helps advance the scope and quality of care. But, particularly during tight budget years, the ASC competes with the hospital's other capital investment needs, including maintenance or new ventures at the main hospital. Ultimately, Memorial administrators must decide which projects to fund.

This occasional obstacle is offset by opportunities the management company model presents to local physicians and our patients. These include:

- Governance structure that physicians determine.
- Financial incentives—including rewards for improving performance--that are consistent with patient satisfaction and safety goals the hospital shares.
- Ensuring compliance with laws, regulations and clinical best practices.
- Influence in recruiting and retaining fellow physicians and employees.
- Freedom to direct and coordinate procedure scheduling.
- Stability and expertise of staff, with low turnover.
- Ancillary services provided by the hospital, including lab, pathology, imaging, physical therapy, housekeeping and dietary.
- As an affiliate of a not-for-profit health system, we treat all patients regardless of their insurance status or ability to pay.
- Better coordination and integration of care for patients.
- Staff productivity and efficiency that place us in the top 10% nationally.
- Ability to deliver cost-effective care.
- Back-up emergency medical resources, should a patient's condition require it.
- The flexibility to share electronic medical records systems, equipment and services with the hospital next door.

Even with a payor mix as diverse as the hospital's, the ASC has continued to be a sound business model financially. It is based on a commendable and sustainable philosophy: the more physicians, nurses and other medical professionals directly influence decisions affecting patient care, the better the outcomes for patients. ◇

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Selling Your Practice to a Hospital-Based IDS

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Deciding whether to sell a medical practice to an integrated delivery system (IDS), including management service organizations (MSOs) or physician-hospital organizations (PHOs), is a complex undertaking. Three considerations are of particular importance to physicians: net income over the next 10 or more years; control; and flexibility to pursue other avenues if the IDS is unsuccessful.

Before joining an IDS, physicians should ask themselves if they really need the hospital's money in order to achieve their practice goals, and if so, how much. They should also consider if the hospital is the best source of funds, and if they will end up repaying some or all of the money to the hospital for management fees or other charges. Finally, they should determine what controls or other concessions the hospital might demand for its money.

To protect their interests, physicians should retain their own independent legal and financial advisors to help guide them through the complex process of joining an IDS. Key questions appear below.

Who is the buyer?

Because of the prohibitions against the corporate practice of medicine, private inurement and kickbacks, the identity of the purchaser can have a significant impact upon the terms of the purchase. The most common form of transaction is for a lay entity to buy the tangible assets of a physician's or medical group's practice. In almost all cases, a professional corporation owned by at least one California physician offers the physician, or physician members of a medical group, an individual employment agreement. Physicians may or may not be offered shareholder status within the professional corporation.

What is being purchased?

Is the physician selling his or her practice assets (such as furniture, fixtures and equipment) or stock (assuming the physician is professionally incorporated)? Note that a PHO, MSO or "foundation" cannot purchase the stock of a professional medical corporation; the stock can only be sold to another professional medical entity. Purchasers generally prefer to buy assets rather than stock in order to avoid assuming the selling physician's liabilities. Whether the physician's accounts receivable will be purchased can be a tricky issue because of the difficulty of valuing the receivables. In some cases, the receivables are not purchased; in others, physicians are required to turn over their receivables in order to help finance the start-up costs of the IDS. Finally, will the physician be paid anything for goodwill?

What is the purchase price?

Physicians are often lured to join an IDS by the prospect of receiving a "premium" price for their practices. While this may be possible in some cases, hospitals may have inurement problems (if they are tax-exempt), as well as fraud and abuse concerns that will prevent them from paying more than fair market value for a physician's practice.

The price of a medical practice is usually a combination of the value of the tangible assets, accounts receivable (if sold), and the practice's goodwill. Tangible assets can be valued at their original cost (such as for medical supplies), at "book" or depreciated value, or at fair market or replacement value.

Determining goodwill is much more difficult. *Goodwill* refers to the "going concern" value of a medical practice. This generally means the ability of the selling physician to transfer to the purchaser the practice's reputation, patients and earnings stream. Among the methods used to determine goodwill are discounted percentage of net cash flow, capitalization of the practice's net earnings in excess of those of the "average" physician in that specialty and geographic area, and market comparables, if any are available.

What are the terms of the management services agreement?

In most IDS arrangements, physicians enter into a long-term management services agreement (MSA) with

their new hospital partner. The terms of the MSA can be more important than the terms of the practice sale. Among the key issues physicians need to consider are what services will be provided pursuant to the MSA; how much physicians will be charged for these services; and whether physicians will retain control (as they should) over all clinical matters.

Physicians should also retain ultimate control over the selection and retention of the chief executive officer of the IDS. Other key issues include how long the MSA is in force and under what circumstances it can be terminated. Finally, physicians need to have the ability to terminate the MSA if the relationship proves unsatisfactory.

Does the MSA violate the corporate bar?

When physicians consider entering into an MSA with a hospital, they should be aware that the Medical Board of California has expressed concern that such an arrangement has potential to violate California's bar on the corporate practice of medicine (see sidebar). According to the medical board, the following business or management decisions and activities, resulting in control over the physician's practice of medicine, should be made by a licensed California physician and not by an unlicensed person or entity:

- Control of a patient's medical records, including determining the contents.
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.
- Setting the parameters under which the physician will enter into contractual relationships with third-party payors.
- Decisions regarding coding and billing procedures for patient care services.
- Approving of the selection of medical equipment and medical supplies for the medical practice.

While a physician may consult with unlicensed entities in making the decisions described above, the physician must retain the ultimate responsibility for the approval of those decisions. The medical board cautions against "non-physicians owning or operating a business that offers patient evaluation, diagnosis, care and/or treatment" or "management service organizations arranging for, advertising, or providing medical services rather than only providing administrative staff and services for a physician's medical practice."[1]

What rules apply to 1206(l) foundations?

California law authorizes certain medical clinics, generally referred to as 1206(l) foundations, to operate without a license. To qualify, the foundations must conduct medical research and health education. They must also contain 40 or more physicians and surgeons who are independent contractors, representing not less than 10 board-certified specialties, at least two-thirds of whom must practice full-time at the clinic. Finally, they must be exempt from taxation in accordance with 501(c)(3) of the Internal Revenue Code. To be tax-exempt, a 1206(l) foundation must:

- Accept, as participating providers, all Medicare and Medi-Cal patients, without discrimination.
- Accept all indigent patients needing urgent care, potentially including necessary follow-up care to hospitalized indigents at free or discounted rates, depending on the patient's financial status.
- Negotiate to participate in Medi-Cal and Medicare contracts, including Medi-Cal managed care contracts.
- Conduct "significant" programs of medical research and health education.
- Ensure that its hospitals maintain an open medical staff but not require physicians who contract with it to refer to its hospitals.

Working on the theory that the law exempts 1206(1) foundations not only from licensure, but also from the corporate practice of medicine bar, hospitals and health systems have sought to create foundations by purchasing all of a large physician group's practice assets, obtaining tax-exempt status from the IRS, and then contracting with the former physician owners to provide medical care to what are now the foundation's patients.

What other questions pertain to medical foundations?

Physicians who are considering selling their practice to a medical foundation should consider many other questions, including:

- How much control of the new foundation will the physician have?
- Is the medical group physician (or physicians) joining a multiple physician shareholder medical group or a single physician shareholder medical group (i.e., a professional corporation essentially controlled by the lay entity)?
- Will the medical group's physicians be shareholders?
- What will be the term of the physician's employment agreement with the foundation-affiliated medical group?
- How will non-physician directors be selected?
- How long does the contract between the foundation and the medical group run?
- How much will the medical group be compensated and for how long?
- Will the hospital have an unfair advantage in contract negotiations and the split of income from capitation and other contracts?
- Will the compensation arrangement be adequate to cover the charity care, research and education obligations that the medical group is being asked to assume? ◇

Reference

1. Medical Board of California, "Corporate Practice of Medicine," www.mbc.ca.gov/licensee/corporate_practice.html (2011).

This article is adapted from CMA medical-legal library document #0218, "Legal and Practical Considerations Concerning Medical Foundations," available at www.cmanet.org. For additional information, contact Samantha Pellon at spellon@cmanet.org or 916-551-2872.

THE SIDEBAR ON THE CORPORATE PRACTICE OF MEDICINE

What is the bar on the corporate practice of medicine?

The bar on the corporate practice of medicine prohibits lay individuals, organizations and corporations from hiring or employing physicians, or from otherwise interfering with a physician's practice of medicine. The bar also prohibits lay entities from engaging in the business of providing health care services by contracting with health care professionals to provide those services. The corporate practice bar does not apply to physician partnerships or professional medical corporations because they are controlled by physicians.

Can hospitals employ physicians?

The California Attorney General has concluded that hospitals may not employ physicians to provide professional services. For example, to the extent a pathologist practices medicine (i.e., prescribes or diagnoses) as a hospital laboratory director, the nonprofessional corporate laboratory that employs the pathologist is unlawfully engaged in the practice of medicine.

To prevent violating the bar, doctors who work in hospitals form physician groups that enter into contracting agreements with hospitals. The medical group is responsible for paying the physicians' salaries, not the hospital. Conversely, the medical staff at the hospital is responsible for granting practice privileges and for oversight of physicians.

Physicians can enter into contracts to provide services at a hospital, but the ability of physicians to share revenue with a hospital is also limited. Revenue sharing can only be done as long as a physician's independent contract with a hospital does not impair the physician's freedom of action, and the compensation received by the hospital is commensurate with its expenses incurred in connection with furnishing the facilities and services rendered. If the payments to the hospital exceed the actual value of services rendered, such overpayments would be considered fee splitting and are illegal.

Are there exceptions to the corporate bar?

Yes. Under limited circumstances, certain types of hospitals may directly employ a physician, including:

Teaching hospitals. A clinic operated primarily for the purpose of medical education by a private or public nonprofit university medical school can charge for professional services for "teaching patients" rendered by physicians who hold academic appointments on the faculty. As long as the facility is used primarily for the purpose of medical education and the services are for "teaching patients," employment is authorized.

Hospital districts. The California Legislature created an exemption for hospital districts to employ physicians under extremely narrow circumstances.

County hospitals. The laws prohibiting the corporate practice of medicine do not apply to counties, given the broad "police powers" granted to them by the state. Thus, counties may employ physicians.

Are there other ways to legally circumvent the corporate bar?

No. Lay entities have attempted to circumvent the corporate bar by engaging physicians in various types of business arrangements, but these strategies are illegal. For example, a lay entity/hospital might agree to handle all business decisions and employ a physician to handle all clinical decisions. However, it is difficult if not impossible to isolate business decisions from those affecting the quality of care delivered to patients. The purchase of a piece of radiological equipment, for instance, could be looked at as a purely business consideration, or as a medical decision, or as an amalgam of both.

In addition to prohibiting lay entities from taking outright control over traditional medical decisions, California law prohibits most lay entities from:

- Having an economic interest in the net profits of a medical practice and/or
- Contracting with physicians on an employment or independent contract basis for the provision of medical services.

If a lay entity has a financial interest in a physician's "bottom line," then the entity has a direct interest in and ability to control the medical side of the business, such as how many hours the physician will work, what medications the physician may purchase, and what type of medical technology should be utilized. This is illegal.

Extreme caution should be taken if a hospital is trying to integrate medical practices through a "friendly" physician who has a majority stock in a medical corporation. An affiliated professional corporation can be used by hospitals to circumvent the bar. The courts and the Attorney General's office can and do find such arrangements in violation of the bar where it appears that the lay entity is controlling the practice of medicine.

For more information, see CMA medical-legal document #0280, "Corporate Practice of Medicine Bar," available at cmanet.org.

Accreditation Does Make a Difference

Loie Sauer, MD, and Christine Kaiser, MD

Dr. Sauer (front row center) and Dr. Kaiser (back row left) with other Breast Center staff (clockwise from top left): Dr. Charles Amezcua, Rose Cook, Dr. Eric Lin, Paula Kelleher, Dr. Marc Fields, Dr. Lucinda Romero and Dr. Yung Do.

Historically, care for breast cancer has been fragmented and inconsistent, with "breast centers" cropping up everywhere adding to the confusion. In 2005, a consortium of 17 professional societies, including those for surgery, radiology and clinical oncology, developed the concept of accrediting breast centers and formed the National Accreditation Program for Breast Centers (NAPBC).

The consortium believed that organized multidisciplinary teams could deliver better breast care if they practiced consensus-based guidelines, monitored outcomes, and were dedicated to quality improvement. Over the next three years, the NAPBC developed a menu of required services and "programmatic" elements that were considered essential for accreditation, along with a list of 27 standards.[1]

The program was met with both applause and skepticism. At a national surgeons' meeting in 2008, for example, a Chicago surgeon was overheard saying, "Great. A flock of self-appointed experts now wants to charge us money to get an accreditation certificate to show that we're better than the doc down the street." On the other hand, the 17 professional societies endorsing the NAPBC had credibility and integrity. What eventually emerged was the perception that NAPBC accreditation was truly about creating centers of excellence.

At Kaiser Santa Rosa, we initially saw the NAPBC criteria as a framework to help organize and improve breast care for our members and patients. We formed the Breast Interdisciplinary Practice Committee (IPC) charged with taking an inventory of our provided services. Meeting monthly and formalized with a charter, the 22-member IPC represented all the services involved with breast care.

The menu of breast services at Kaiser Santa Rosa includes board-certified physicians in all breast-related specialties—radiology, surgery, pathology, plastic surgery, medical oncology and radiation oncology—along with specialty-trained nursing professionals. Our imaging services encompass digital mammography, ultrasound and MRI, and biopsies are performed using all of these modalities.

Linking all of these together is Kaiser's powerful electronic health record, KP HealthConnect, which displays "health maintenance prompts" for any patient who shows up on campus. These prompts can lead to cancer detection, as in the case of one patient whose breast cancer was found because she went to Kaiser for a new pair of glasses. The optical clerk said to her, "I see you're overdue for a mammogram, and I can make that appointment for you today."

Dr. Sauer, a surgeon, and Dr. Kaiser, a medical oncologist, co-chair the Kaiser Santa Rosa Breast Interdisciplinary Practice Committee. Emails: lsauer@sonic.net, christine.c.kaiser@kp.org

The mammogram showed a spot that proved to be a small cancer.

In February 2010, the Breast IPC at Kaiser Santa Rosa decided to pursue NAPBC accreditation. The next 16 months proved to be a flurry of data collection and analysis, as well as a reflection on strengths and weaknesses. As expected, scrutiny offered opportunity. In addition to reviewing data, we also opted to talk to patients and learn from their experiences. We held a formal focus group with a professional research team for unbiased feedback, giving patients a candid forum to reflect on their experiences with breast care at our facility. What came out was generally favorable and informative.

A common thread expressed by patients was that they would have liked to meet doctors from all the breast specialties earlier in the treatment process. This preference diverged from the traditional "sequential" treatment model, where a patient first has surgery, then "graduates" to medical oncology, then radiation, then plastic surgery. The patients said they would have preferred to get a better grasp of the whole process, with up-front contact with all the specialists, rather than a vague sense about the unknown future steps ahead of them.

From this feedback, as well as a site visit to a multidisciplinary breast cancer clinic at Kaiser Santa Clara, we launched a similar clinic at Kaiser Santa Rosa. Beginning in November 2010, newly diagnosed breast cancer patients met with a surgeon, a medical oncologist, a radiation oncologist, and sometimes a plastic surgeon, in one visit, spending about 30 minutes with each physician. The patients also met with a nurse navigator/educator. The medical team previewed the patient's imaging, pathology and health history and discussed the preliminary care recommendations. After meeting with the patient, the care team again reviewed and modified the care plan.

This team approach was a hit among patients. They said that the combined visit gave them a perspective on the whole picture, not to mention the convenience of streamlining what would have been multiple consultations with different specialists. Patients and family members also appreciated having to take only one day off work, park the car only once, and make only one copay.

At the conclusion of 2010, we predicted that we could finish our preparation and meet the NAPBC standards for accreditation. We submitted our preliminary application and aimed for a final survey review in June 2011.

Our activity in preparation for accreditation was intense. We gave the NAPBC case summaries of the 201 patients diagnosed with breast cancer the prior year, and we quantified numerous variables with respect to cancer stage and treatment rendered. The NAPBC approved our summary statistics and then required 37 "charts" to be pulled for chart review with the survey team. Providing *paper* charts was quite a painstaking task for providers used to a completely electronic health system. Radiology reports, pathology reports, operative reports, all-specialty consultation notes, follow-up progress notes, genetic counseling and testing results—all had to be printed, punched and filed in 3-ring binders with labeled tabs. Fifteen similar charts of patients with benign breast disorders were submitted as well.

On the day of the site visit, the NAPBC reviewer joined us for presentations with the entire Kaiser Breast Care team. He toured the imaging facilities, education center and breast resource center; met with leaders of all the clinical departments; attended tumor board and the multidisciplinary clinic; and then sat for hours reviewing charts, which he scrutinized for compliance with a dozen treatment standards.

At the afternoon wrap-up, the reviewer's conclusion was that Kaiser Santa Rosa had passed, and in many cases exceeded, the expectations for all 27 standards. The survey team called Kaiser's program an example

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of "clinical best-practice in the delivery of breast care services." We were granted a full three-year accreditation by the NAPBC, making us the first nationally accredited breast care center in Sonoma County. Of the 375 breast centers accredited nationwide, 24 are in California, including five at Kaiser facilities.

What did we learn and what did we gain from the accreditation process? We learned the benefit of self-reflection as an opportunity to improve. We felt the pride of seeking excellence. We worked better as a team. Historically known for affordable healthcare, Kaiser now promotes group excellence as its trademark.

The pre-treatment dialogue is a particularly good example of teamwork. The ever-evolving field of tumor biology is changing the landscape of treatment algorithms, such that some women benefit from chemotherapy before surgery. Some women opt for reconstructive procedures at the time of cancer surgery, and a conversation about whether radiation is needed will change the decision about reconstruction options. Sitting down as a team with all the specialists talking to each other before any treatment is offered is a big leap in improving care.

The accreditation process also demonstrated how data-rich Kaiser is. Kaiser's breast cancer tracking system was launched in 1995 and is reported out annually, collecting data from 19 Northern California facilities on rates of screening, rates of callback for diagnostic mammograms, biopsy rates, percentage of abnormal pathology, stage of cancer diagnosed, breast conservation rate, sentinel node, and other variables. Page after page of bar charts and pie charts make the system a self-reflective body of data from which no outlier can hide.

The data are also used to identify performance improvement metrics, and a noteworthy effort is underway in the Kaiser Northern California region to shorten the time between imaging and diagnosis. In Santa Rosa, we mapped the process that involves radiology, pathology and surgery to identify the steps that could be improved. The IPC hopes to compress the diagnostic process and shorten the number of sleepless nights for these anxious patients.

Another standard for NAPBC accreditation is participation in clinical trials. Kaiser has an active research program, and Santa Rosa is a satellite of the regional oncology research group centered in Vallejo, where all open trials are reviewed for merit. Santa Rosa currently has more than 10 open clinical trials for breast cancer patients, and all patients are screened for eligibility by the clinical trials team.

The NAPBC recently surveyed leaders of the accredited breast care programs, asking whether the preparation for the survey process led to improvements. Eighty-five percent of the respondents reported that significant changes had been made to strengthen their breast program in preparation for accreditation review. The fact that accreditation is purely a voluntary process is fundamental to its success. Had it been a mandated process, the same steps—data gathering, quality improvement, chart audits—would have been oppressive.

As health care in the United States evolves toward transparency, accountability and quality outcome reporting, programs like the NAPBC can facilitate clinical excellence by providing structure and a road-map to community centers wishing to organize their programs. As the NAPBC governing body states: "We must constantly strive to improve the care of our patients. We believe accreditation does, indeed, make a difference."

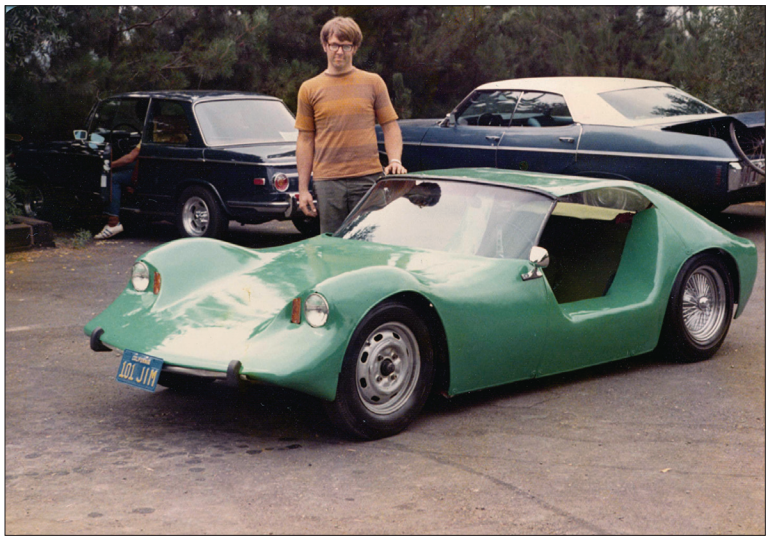
The fact that 375 centers have put forth the effort to achieve accreditation nationally, and 125 more are in the process, attests to the view that accreditation does make a difference. ◇

Reference

1. Winchester DP et al, "The National Accreditation Program for Breast Centers," *Bull Amer Coll Surg*, 33:10;13-17 (2008).

The Mode Not Taken

Brien Seeley, MD



Dr. Seeley and his home-built electric car, circa 1970.

For most of us in Sonoma County, the road to San Francisco is Highway 101. The morning commute on this road often entails a 90-minute slog through gridlocked traffic. Four years ago, my local all-volunteer nonprofit group began working toward a much faster and safer "road." That other road is the mode not taken, what NASA calls a "highway in the sky." This high-capacity, futuristic, 3D transportation system took a giant leap forward at the historic Green Flight Challenge that our group conducted at Sonoma County Airport last fall. What follows is the story of how a hobby of building home-made cars ended up putting me in charge of that event, which was sponsored by Google.

The story begins in the spring of 1969, when I proposed marriage to Anne Powell, the valedictorian daughter of an ophthalmologist in Walnut Creek named Lyle S. Powell. Lyle led a double life. By day he was a respected ophthalmologist, but at night he built racing cars in his backyard machine shop. When I became his son-in-law, he began teaching me how to do the same. His shop was not a grease pit of dirty fingernails and profanity. Rather, he built his race cars like a scientist, using precision calculations and physics. Lyle inspired me. I gradually turned into a geeky gear-head.

During weekends in my second year of medical school at UC San Francisco, I set about building an electric car. A kind and knowledgeable UC Berkeley lab engineer named Rollin Armer served as my mentor about electric motors and supplied me with a surplus 168 volt 50 horsepower beauty built by GE. Lyle helped me design a lightweight race-car chassis that could still carry the 1,260 pounds of lead-acid batteries the car required. I molded a custom fiberglass body and installed a four-speed transmission. I licensed this simple but fast zero-emissions car as freeway legal and drove it to the hospital each day as an intern. It achieved more than 70 mph, which way back then may have been the world's fastest electric car. The range, though, was only 30 miles. Meanwhile, Lyle had turned his attention to working on airplanes, and I soon discovered the joy of flying. I devoted my two-week vacation from eye residency at UCSF to obtaining my pilot's license. Anne became my enthusiastic copilot.

After starting my practice in Santa Rosa in 1977, I joined Santa Rosa's Experimental Aircraft Association (EAA), Chapter 124, where I met a wonderful group of like-minded people who were passionate about building their own aircraft. That same year, I helped Lyle build his sleek, two-seat Rutan Varieze that could achieve 35 mpg at 178 mph, making 70 passenger mpg. It seemed to me that aircraft should aim to be more environmentally friendly. In 1979, I acquired my first airplane, a fixer-upper 1966 Mooney M20E with four seats and a cruise speed of 178 mph at 15 mpg. Over the next two years I modified the plane for more speed on less fuel, eventually achieving 26 mpg at the same speed, making 104 passenger mpg.

This fascination with efficiency became a consuming passion. In 1981, my dear friend Dr. Larry Ford, a dentist and aircraft builder in Sebastopol, joined me and a few other EAA members in founding a 501(c)(3)

Dr. Seeley, a Santa Rosa ophthalmologist, is president of the Comparative Aircraft Flight Efficiency Foundation.

nonprofit organization called the Comparative Aircraft Flight Efficiency (CAFE) Foundation. Its purpose was to bring the most advanced small experimental aircraft to Sonoma County to compete in an annual flight contest that would measure their mpg and speed. With fantastic volunteer support from EAA Chapter 124 members, and the enthusiastic hospitality of Dee Tollefson, the fixed-base operator at the old Santa Rosa Air Center, CAFE staged this contest each summer as a 400-mile "race" over Northern California. These CAFE 400 races ran for 10 consecutive years and brought America's top aeronautical designers to Santa Rosa.

In 1986, an electronics genius who worked at HP in Santa Rosa, Steve Williams, designed an elegant portable precision instrument called the barograph that could measure the speed and altitude of an aircraft and record it to memory. Steve joined CAFE, and his barograph became the CAFE Barograph, a device whose legendary accuracy earned it the FAA's designation as the standard for aircraft certification.

In 1992, the CAFE Barograph and CAFE's impeccable safety record led EAA National to fund the building of a CAFE Flight Test Center at Sonoma County Airport, where we tested and reported on top experimental aircraft. In 1995, we were invited to test in NASA's wind tunnel, and the FAA supplied us with a major grant to continue our flight research on new innovations in flight testing. Ten years later, NASA selected the CAFE Foundation as their flight test agency to conduct the Centennial Challenges for aeronautics. These were to be technology prizes with large cash awards for aircraft that could achieve new breakthroughs in efficiency, speed and low noise emissions.

Inspired by his invention of human-powered flight, I invited Dr. Paul MacCready to be the keynote speaker at the first-ever CAFE Electric Aircraft Symposium in San Francisco in 2007. The presence of Dr. MacCready (who has since passed away) enabled me to recruit additional faculty, including experts from NASA and Boeing and major university aerospace professors. Google founder and CEO Larry Page, who has an abiding interest in clean transportation, was one of the 18 people who attended. The symposium concluded with an upbeat presentation about the amazing potential energy storage breakthroughs that were on the horizon. The dream of electric flight had begun.

The prizewinning Pipistrel Taurus G4 during the Green Flight Challenge.

That dream became more compelling as the problems of climate change, surface gridlock and dependency on foreign oil loomed ever larger. We increasingly thought that electric aircraft might be able to help solve all these problems. Over the next two years, CAFE convinced NASA to launch the Green Flight Challenge (GFC), a flight competition open to hybrid, gasoline and electric aircraft that could achieve 200 passenger mpg. The GFC was to offer aviation's largest-ever prize: $1.65 million, funded by NASA.

Meanwhile, my daughter, Ellen, was drafting her UC Davis master's thesis on walkable communities and pocket parks. She suggested that electric aircraft, if quiet enough, might be allowed to operate at small, close-in, two-acre airports located within walking distance of destinations. She coined the name "pocket airports," and the name stuck. Calculations showed that operations at pocket airports would use 1,000 times less land than major hub airports yet handle just as many flights. The pocket airports would demand aircraft with ultra-low noise emissions, ultra-short takeoff, high mpg and foolproof computerized flight controls. I presented this vision at the 2010 Electric Aircraft Symposium, and NASA took notice. They funded a trip for me to Hampton, Va., so I could deliver a formal colloquium on the pocket airport concept to their leading aeronautical engineers.

Back in California, the CAFE Electric Aircraft Symposium had grown each year, becoming an annual event. The faculty at our fifth annual symposium, held at the Flamingo Resort in Santa Rosa in April 2011, included NASA's chief scientist, the world record battery innovator, the chiefs of aeronautics at Penn State University and Georgia Tech, and Lawrence Livermore's renowned Dr. Ben Santer, a leading climate scientist. At the symposium, Dr. Larry Ford debuted the team aircraft that were entered to compete in the GFC. Fourteen teams from around the globe had registered. Soon thereafter, Google became the major sponsor of this breakthrough event.

The "Green Flight Challenge sponsored by Google" took place in the skies around the CAFE Flight Test Center from Sept. 25 (Dr. MacCready's birthday) to Oct. 1, 2011. The first-place Pipistrel Taurus G4 from Penn State University

won $1.35 million by achieving 403.5 passenger mpg at 107 mph in an electric-powered four-seat aircraft that twice flew the 200-mile course non-stop on *batteries!* Those batteries were charged for each race by clean geothermal power at the Google-funded CAFE Electric Aircraft Charging Station, the first of its kind in the world. This high-powered, station at CAFE's hangar can charge 12 electric aircraft at once. It was designed and installed by local engineers and builders Rick Guggiana, Steve Williams, Alan Soule, Dave La Fever, Tim Seeley and Francis Farrell.

The GFC included another game-changing performance: the e-Genius all-electric two-seat aircraft. Built at the University of Stuttgart, this plane won $120,000 for second place while demonstrating a takeoff noise level of just 59.5 decibels at a 250-foot sideline on the runway. This incredibly quiet performance won the inaugural Lindbergh Prize for Quietest Aircraft. Charles Lindbergh's grandson, Erik, awarded the $10,000 prize, which was funded by Jeannie Schulz, wife of famed Peanuts cartoonist Charles M. Schulz, namesake of the airport at which the record was set.

The e-Genius used a direct-drive propulsion system whose only moving parts subject to wear are ball bearings. Rather than requiring overhauling of pistons and cylinders every 2,000 hours, brushless electric motors can go 50,000 hours before needing bearing replacement. Electric propulsion does not require oil or water pumps and hoses that are vulnerable to failure. These attributes could help make small aircraft travel safer than traditional airlines.

NASA's Flickr site for the GFC set a new record for web hits. The usual traffic is 3,000 hits per day. Big events like the Soyuz hookup get 75,000 hits. The GFC got 1,087,000 hits.

NASA officials called the GFC a "Lindbergh Moment." Indeed, if fully implemented in the pocket airport paradigm, green flight may prove to be the most socially and economically significant achievement in transportation since Charles Lindbergh's historic 1927 flight. The GFC demonstrated to a global audience the first instance of practical electric-powered aircraft that can offer fast, ultra-quiet, emission-free, safe, cross-country personal travel without having to build more roads.

NASA television filmed the GFC awards ceremony at Moffett Field's NASA Conference Center, where global media were gathered to witness the event. The ceremonies culminated with the awarding of the beautiful CAFE Green Flight Trophy to Dr. Jack Langelaan of Penn State University, the team leader for the winning Pipistrel Taurus G4.

Dr. Langelaan receiving the Green Flight Trophy.

Besides the Pipistrel and the e-Genius, two other remarkable aircraft flew in the GFC. More than 200 students from Embry Riddle Aeronautical University in Florida pitched in to convert a German-built Stemme S10 into the world's first hybrid powered aircraft. Another team, led by National Soaring Champion Jim Lee, entered the Phoenix motorglider, an extremely efficient aircraft built in the Czech Republic.

NASA's Highway in the Sky has been dreamed about for decades. It now appears to be not only within reach, but well worth taking. Based on statistics from the Bay Area Metropolitan Transportation Commission, a Highway in the Sky system using just 17 pocket airports in Sonoma and Marin Counties could undo the freeway gridlock that plagues travelers to San Francisco every morning. The CAFE Foundation is looking forward to creating the next GFC prizes that could make that dream real.

Serving as CAFE's President these last 30 years has been one of the most fulfilling and enjoyable experiences imaginable. Working with a truly dedicated group of diversely gifted characters makes me feel like I'm a member of a legendary gang. They have an uncanny gift for solving highly technical challenges with brilliantly simple solutions. Getting to know the amazing array of leaders, scientists and aeronautical geniuses who have been attracted to CAFE's many events has been a great ride.

We hope to announce the plans for the next GFC at the sixth annual CAFE Electric Aircraft Symposium, to be held at the Flamingo Resort in April. ◇

Email: cafe400@sonic.net

Further Reading

The GFC received global media attention. Links to a few of those stories, including a related story about electric cars, can be found below.

- cafefoundation.org/v2/gfc_2011_media.php
- news.yahoo.com/paris-launch-electric-car-sharing-program-151608561.html
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To Whom Much is Given . . .

Liana Meffert

Some lessons you can learn by walking out your front door. For others, you may have to travel a bit farther. During the summer of 2011, I chose the latter path, traveling with my father, Dr. Stephen Meffert, on a medical mission to Nepal. When people ask me about the trip, I have a hard time doing it justice. The statements I manage sound flat and clichéd: "It was quite an experience," "I learned a lot," and, my personal favorite, "It was unlike anything I have ever done before." Few people get the full story, and even then it seems as if they are peeking through a keyhole.

I think it is fitting to begin my story with a quote from Mark Twain's *Innocents Abroad:* "Travel is fatal to prejudice, bigotry and narrow-mindedness."

There are always things we take for granted in our chaotic lives: things that go unspoken during Thanksgiving prayers and evade the expanse of our wandering thoughts while we languish in traffic. Personally, I've always taken my ability to communicate effectively with others for granted. While in Nepal, I was impressed to discover how location-specific my social skills are. At breakfast one morning, I was frustrated to find that the waiter shook his head "no" to every food I tried to order. We went back and forth for a while. I would order alternative options and he would reply with a shake of his head. Finally, I conceded that there would be no breakfast that morning and said "Okay." He wrote something down and retreated to the kitchen. Ten minutes later he produced all that I had ordered. I took note in an email home that day: "I think I've read that in some places to shake your head means 'yes' and to nod means 'no.' Perhaps, I have arrived at that 'some place.'"

Nepalese girl takes a break from standing in line.

I noticed with dismay that much of the subtle United States body language in which I was so well versed was rendered meaningless in Nepal. In Nepal, if I turned around too fast in crowded areas, my face would end up in the chest of whoever stood waiting behind me. My movements became much more concise and constricted, the result of a subconscious effort to maintain what little bit of "personal bubble" I had left.

At Lumbini Hospital, I met a resident physician whom I affectionately referred to as Bee for fear of butchering the pronunciation of her name on my American tongue. She took an interest in me early in our visit, standing close as we observed surgeries and helping me cinch up the XXL scrubs that drooped around my ankles. Our friendship was encouraged by two key components: she could speak nearly fluent English, and we were within four years of age.

Bee was fundamental in my interpretations of Nepalese culture. When people raised their voices excitedly, I leaned over and asked her, "Are they mad at each other?" No, they were not. And when my dad and I realized that the respected greeting in Nepal was a slight bow of the head accompanied by "Namaste," we both questioned if it was appropriate for us to make this gesture as well. "They would like that," Bee said. Mainly though, I relied on the ubiquity of a smile.

The bindi was another source of cultural curiosity. The stunning red dollop of pigment, sometimes in the form of a sticker, was placed on the forehead of men and women alike. Bee explained that it was originally intended to signify that a woman was married, but that men wore it (higher up on their forehead than women) after visiting temples or on special occasions. More

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recently, the bindi has become decorative wear for both adults and children. At first I was annoyed by the inconsistency of its use, but then I glanced at my hands, realizing I was wearing a ring on my left-hand ring finger. At 18 and happily unmarried, I recanted my argument.

When I reviewed photos after the trip, the increasing ease at which I approached people for photographs was evident. Initially, I was concerned that they would react angrily or that it would just be awkward. Usually it was, but blank stares were a small price to pay for the moments I captured, and a friendly smile often won the participants over later. I realized that when people look at photographs, they open themselves to a view composed entirely at the photographer's discretion. The world they see is the photographer's world. In my vision of Nepal, I saw people whose lives were much different from mine, certainly much harder than mine, and if I could convey a tiny sense of that, then I had succeeded in my portrayal. For other sensory details, though, I was at a loss. The smell of warm rains during monsoon season, the sounds of schoolchildren singing outside the hotel window—those stay with the heart of the traveler.

In an email home, my growing respect for the Nepalese was apparent: "There are no appointments for the patients, so any patient that is not seen that day will return the next in the hopes that they will finally be seen. There is so much to say. I guess I will conclude with an observation that impressed Dad and myself: the patients are put under local anesthesia as opposed to general. They lie perfectly still and wide-awake for what can sometimes be three or four hours (as we discovered in the afternoon). Dad and I watched the patients' hands for signs of movement, perhaps a slight fidget, but to no avail. One time, a patient began talking; we surmised he was experiencing some pain. The nurse applied a topical numbing gel and they continued. There was another boy seen in clinic, maybe nine or ten years old. The boy was complacent throughout the appointment; even holding still while the doctor treated his eye with the laser. These people are desperate for help—and very tough."

Sometimes the guilt for all that I have been given, things that may never be attainable for others, is hard to reconcile. I spent days after my visit to Nepal clearing out my room, not only to prepare for my impending departure for college, but also for personal sanctity. I wanted to remove the unnecessary from my life—yet I still held onto a shoe collection any girl would be proud of and more clothes than I could wear in a week. I recalled the story of Siddhartha Gautama, better known as Buddha. He was born into a life of luxury and sheltered by his father, a king who did not want him to witness the suffering that occurred outside the palace walls. At 29, Buddha finally traveled outside the safe walls of his palace. His journey resulted in four encounters that subjected him to the sorts of suffering he had never known. Unable to come to terms with the suffering that others experienced, Buddha left his newborn son and wife to seek a path of enlightenment.

Patient waiting at Lumbini Hospital.

In Nepal, I felt as though I had stumbled upon a modern-day version of the four encounters. I saw my naïve interpretations of the world losing their grip on the 22-hour flight to Nepal, my understanding of life sliding off the wings of airplanes. How do I revise my perceptions with newfound consideration of the injustices in our world? A well-known quote has woven its way through generations of my family: "For those to whom much is given, much is expected." I heard it driving to school as a child, and I am sure I will hear it again leaving for college this fall. Understanding what I have been given has empowered me with the ability to give back.

During my trip, I read Malcolm Gladwell's *Outliers*. The book was a perfect supplement to what I witnessed every day and resounded whole-heartedly with the thoughts running through my head each time I stepped out into the streets. Why me? What right do I have to such a comfortable existence over all these other people? Recent estimates indicate that 1.7 billion people on this earth live without basic necessities. I will never be one of those 1.7 billion people.

Outliers confirmed that my chances of success exceed those of other people purely because of a series of predetermined factors: the nature of my heritage, my DNA, my ancestors, the extent of my parents' education. Much of what I was "given" was the circumstance of my birth. What is "required" of me is nothing more and nothing less than to begin to bridge the gap between myself and the billions of people who did not grow up in a house full of books. To whom much is given, much is expected. Halfway around the world, I finally grasped the meaning of my great-grandmother's words. ◇

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Annual Dinner Honors Award Winners

Dr. Kirk Pappas addresses the crowd after receiving the Outstanding Contribution to SCMA award.

More than 140 SCMA members, spouses and guests crowded into the Vintner's Inn in Santa Rosa on Dec. 1 to honor several physicians and community organizations for their remarkable accomplishments. Recognitions and awards were presented to Dr. Allan Bernstein, Dr. Jessica Les, Dr. Enrique González-Mendez, Dr. Kirk Pappas, Operation Access and Tricia Hunstock (see page 37).

Dr. Pappas, who received the Outstanding Contribution to SCMA award, made a notable acceptance speech. The concluding section appears below.

"Our country is divided, fractured around our profession and the delivery of healthcare. There is a lack of collaboration in Sacramento and Washington, DC, that is paralyzing not just medicine and healthcare but our entire nation's economy and future.

"Two weeks ago, I was in Washington, DC, for some work in one of my other jobs. It was a week where every day the front page of the *Washington Post* had articles about healthcare and healthcare reform. One day there was an entire section of discussion of the paralysis of the "Super Committee" and the effects on dollars and healthcare policy. But when I searched for our voice as physician leaders, it was nowhere to be seen. Our voices are not heard because we are not together with our thoughts as physicians.

"One morning I went for a run from our hotel, near the Capitol, down along the National Mall, past the monuments. It was a drizzly pre-dawn when I left, but the sun was shining by the time I raced up the steps of the Lincoln Memorial. I was not playing my usual Springsteen, but rather my special DC music for the Lincoln Memorial, the Jimi Hendrix version of the "Star-Spangled Banner."

"As I stood at the feet of Lincoln's statue, I was in awe and noticed that even at such an early hour there were people there of all ages and backgrounds. As usual most of the people were around the speech to the left of the statue, the Gettysburg Address. The speech that resonated with me, however, was on the right: his Second Inaugural Address. I will read the last paragraph:

With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations.

"Lincoln spoke these words at a very difficult time during our country's history. He valued the union above all, and he would beg, borrow and steal to preserve it. He sacrificed all he had to maintain the unity of our country.

"It seems to me that Lincoln's words have relevance to the fracture within our own society—economically, socially and especially within healthcare. We have a responsibility as physicians to heal (remember the Hippocratic Oath we took). It's also our obligation to model the leadership behavior that is necessary to heal the fractures within our own profession and within healthcare. Our county medical association has a long history of being able to work together and see things from others' perspectives. I encourage all in this room to continue to find ways to work together …" ◇

Tricia Hunstock (left) received special recognition for her presidency of both the CMA Alliance and the SCMA Alliance. The presenter was Ann Hurd.

Dr. Jessica Les (left) received the Article of the Year award for "View from the Gurney," which appeared in the Fall 2011 Sonoma Medicine. *The presenter was Dr. Deborah Donlon.*

Dr. Allan Bernstein (right), accompanied by his wife, Laura, received the Outstanding Contribution to the Community award for his groundbreaking work in headache management and research, and for his efforts to improve specialty access for the uninsured. The presenter was Dr. James Gude.

Dr. Enrique González-Mendez (right) received the Outstanding Contribution to Sonoma County Medicine award for his contributions to the Santa Rosa Family Medicine Residency and his service to the local Latino community. The presenter was Dr. Rick Flinders.

Dr. Kirk Pappas (left) received the Outstanding Contribution to SCMA award. The presenter was Dr. Joshua Weil.

Operation Access received a Recognition of Achievement award for its efforts to help low-income, uninsured patients receive surgical and specialty care. Several volunteers were honored, including Dr. Richard Auld (left), Marlene Russell, and Dr. Henry Flores. (Not pictured: Dr. David Quenelle.)

Prints of these and other photos of the SCMA Awards Dinner are available from the photographer, Sara Wilbur, at **sarawilburphotography.zenfolio.com/p234748443.** The password to access the photo gallery is **scma2011**.

Pharmaceutical Warfare

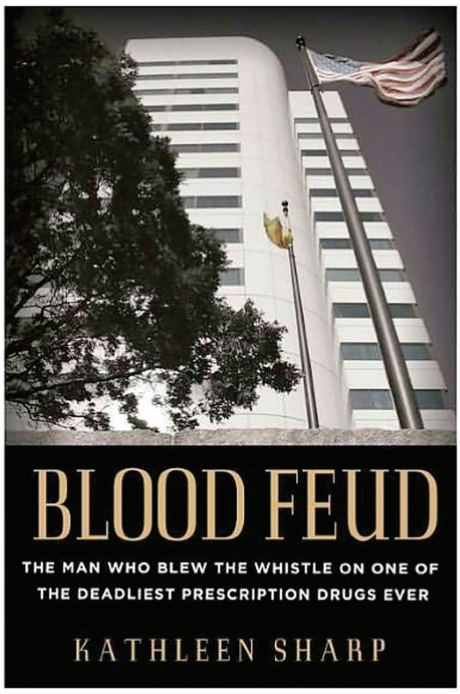
Deborah Donlon, MD

Blood Feud: The Man Who Blew the Whistle on One of the Deadliest Prescription Drugs Ever, by Kathleen Sharp, 432 pages, Dutton (2011).

When the structure of erythropoietin was first isolated, the drug showed promise for treating and preventing anemia in chronically ill patients. Improved quality of life for those patients seemed certain to follow. According to journalist Kathleen Sharp, however, the pharmaceutical companies that marketed erythropoietin employed shady techniques to gain market share and profit, often at the expense of patient safety and well-being. Her nonfiction book *Blood Feud* focuses on two companies that marketed brand-name versions of erythropoietin: Johnson and Johnson (Procrit) and Amgen (Epogen).

We first meet Mark Duxbury, a novice sales rep hired to sell Procrit for Ortho, a division of Johnson and Johnson. His competition: a cadre of sales reps selling Epogen for Amgen. Early in their relationship, these companies sign an agreement to divide their target markets into dialysis and non-dialysis patients. Quickly, the race to reach sales targets leads to overt stealing of business between the two companies, and lawsuits follow. Adding intrigue to the story is the erythropoietin doping that sweeps the international cycling community, leading to untimely deaths and irreversible injuries.

Duxbury makes a compelling protagonist. He begins as an optimistic young salesman with an enthusiastic belief in Procrit, certain it will help patients live better lives. He is primed to steal Amgen's business while his bosses plead ignorance to the practice. He experiences "gaslighting," in which company ploys make him believe he is insane, and creepy guys peer in his home's windows once he becomes a whistleblower. His health and personal relationships suffer. It's easy to feel sympathy for the lonely salesman who spends untold hours on the road, earning millions for the company, yet can barely afford his mortgage and child support.



Even more compelling for a physician audience, however, are the themes brought to light by Sharp:

- Some drugs (such as Epogen and Procrit) are awarded FDA approval, and are promptly sold and administered to patients, even though the companies that produce them never complete the required safety studies. There is a lapse in FDA oversight, and patients are harmed.
- Sales reps are frequently offered access to patient charts to determine eligibility in studies, which violates HIPAA and patient confidentiality laws. The doctor and office staff are often too busy to perform the chart review function themselves.
- Pharmaceutical companies are not the only parties reaping financial gain from the sales of their drugs. Physicians, hospitals, and dialysis and oncology centers are sold drugs such as Procrit at a discount (or given a free "trial" supply) and then bill insurance and Medicare at full price. The Department of Justice provides insufficient oversight against this type of fraud.
- The marketing of a drug's use for an off-label indication to physicians is illegal, yet common.
- Once a drug has FDA approval, it is fairly easy to get a higher dosage of the drug approved, despite lack of safety data to back up the dosage increase. These higher doses result in greater profits for pharmaceutical companies and may contribute to patient morbidity and mortality.

Sharp is an award-winning investigative journalist who has completed a health care fellowship. After reading her previous work, Duxbury approached her in 2004 and asked her to write an article telling his story. After a time she agreed, and spent four years conducting over 100 interviews across the country. Of note, executives at Johnson and Johnson repeatedly declined to be interviewed for the book. Aside from some overly dramatic foreshadowing, Sharp is a good writer and presents her case well.

The book's most important message is that it is dangerous and unethical to allow strong financial incentives to subvert the health and well-being of the public. Legal professionals move fluidly between the public and private sector, meaning that corporate interests

Dr. Donlon, a Santa Rosa family physician, chairs the magazine's editorial board.

can find their way into the FDA and the Department of Justice. Meanwhile, physicians have a responsibility to keep their patients safe, and should not have their judgment clouded by the financial reward of dispensing a particular drug. Many of these factors explain why the United States has the highest expenditure in the world on health care, yet poor patient outcomes relative to other developed nations.

Woven into the story of Mark Duxbury and his colleagues at Johnson and Johnson is that of Jim Lenox, a 54-year-old cancer patient who receives several high doses of Procrit as an adjunct to his treatment. As the book opens, his widow thinks to herself: "In light of her husband's slow, torturous death, that injection loomed large in her mind. Had that drug killed her husband? And were others dying in the same grotesque way?"

Blood Feud provides a starting point for closer examination of the American health care and justice system, and makes a compelling argument for change. ◇

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Will fee-for-service medicine survive?

Jeff Sugarman, MD

As the business of delivering medical care becomes increasingly consolidated and the private practice of medicine vanishes in the winds of large integrated medical corporations, many local doctors and patients have been left wondering about the future of the delivery of medical care in Sonoma County. Will this revolution improve quality? Will it help contain costs?

As a patient, I wonder how the changes will affect my relationship with my doctor. If I need to be hospitalized, will my doctor care for me in the hospital setting? Will my health information be known to the unfamiliar team of physicians and other providers assuming my care?

As a physician, how will the changes affect my ability to practice medicine the way I think is most appropriate? How much autonomy will I lose? Will my salary decrease? Will I have a choice?

Hospital employment of physicians has increased in the past decade. Private practice physicians have struggled with lower reimbursement rates in the face of an inability to collectively bargain, coupled with the rising costs of running a practice. Many younger physicians also want a better balance of work and lifestyle. All these factors and more have attracted physicians to join larger networks and hospitals.

Dr. Sugarman, a Santa Rosa dermatologist in private practice, is president of SCMA.

Desiring to protect their own viability, hospitals need to employ physicians to gain market share, shore up referral bases and capture admissions. Physicians may be lured by the promise of higher salaries from larger integrated medical corporations and hospital systems—salaries that are garnered through more aggressive contract negotiations with insurance companies. Advances in technology have allowed integrated multispecialty groups and hospitals to communicate more effectively through the electronic medical record.

These trends, however, do not guarantee clinical integration or cost-cutting. According to a recent study, the trend of hospital-employed physicians may actually increase costs through higher hospital and physician commercial insurance payment rates and hospital pressure on employed physicians to order more expensive care.[1] Clearly, there may be important differences between the not-for-profit hospital systems and the for-profit hospital systems encouraged by a fee-for-service payment system that rewards volume.

In the current climate, many policy makers in Washington, DC, have predicted the end of fee-for-service medicine. Proponents of a new payment system argue for swapping a service incentive program for one in which payments are made based on an episode of care. Yet-to-be-mandated rules may transform fee-for-service into global reimbursements for a particular medical condition. In my world as a dermatologist, for example, a standard payment may be offered for managing a skin cancer of a certain size and location, or for managing a particular severity of psoriasis. Physicians will then choose the management plan, knowing they will be paid the same no matter which one they choose. Shifting financial risk in patient care to physicians in this way may lead to its own perversions in medical treatment.

Will fee-for-service medicine survive? If it does, in what form? If (when) it does not, will its demise be a quick affair, like a falling row of dominoes, as new regulations force dramatic changes in physician behavior? Or will bickering between the many powerful stakeholders—such as hospitals, large integrated medical corporations, organized medical societies and pharmaceutical companies (notice I left out individual physicians who have no power)—result in a prolonged, painful demise? Only time will tell. ◇

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Dr. Amy Shaw, Primary Care Oncology & Survivorship Program talks with Dr. Charles Elboim, Breast Surgeon.

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